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No. 86-1419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

STATE OF OREGON, DEPARTMENT OF HUMAN RESOURCES; RICHARD C. LADD,

Petitioners,

vs.

COOS BAY CARE CENTER, an Oregon Corporation, Guardian Ad Litem; HANNAH SCHWANKE, Guardian Ad Litem for David and Steven Schwanke; and SANDY MAUER, Guardian Ad Litem for Tami Mauer,

Respondents.

Brief of the States of Colorado, Hawaii, Idaho, Indiana, Kansas, Maine, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Tennessee, Utah, Vermont, Virginia, Washington, and Wisconsin, as *Amici Curiae* in Support of Petitioners

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Respondents.

BRIEF OF THE STATES OF COLORADO, HAWAII, IDAHO, INDIANA, KANSAS, MAINE, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW JERSEY, NEW MEXICO, NORTH CAROLINA, NORTH DAKOTA, OHIO, OKLAHOMA, TENNESSEE, UTAH, VERMONT, VIRGINIA, WASHINGTON, AND WISCONSIN, AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Rule 36.4 of the Rules of this Court, the States of Colorado, Hawaii, Idaho, Indiana, Kansas, Maine, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Tennessee, Utah, Vermont, Virginia, Washington, and Wisconsin, as amici curiae,

respectfully submit this brief in support of the petition for writ of certiorari submitted by the State of Oregon Department of Human Resources seeking review of the decision of the United States Court of Appeals for the Ninth Circuit issued November 3, 1986, 803 F.2d 1060 (9th Cir. 1986), reversing the United States District Court for the Western District of Oregon, and finding that respondents' complaint states a claim for which relief may be granted under the Civil Rights Act of 1871, 42 U.S.C. § 1983.

INTEREST OF THE AMICI CURIAE

Each of the amici States participates in the Medicaid program established by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*, and in that manner provides medical assistance to needy eligible persons who are unable to provide for their medical care from their own resources.

As required by federal law, the programs of each of the amici States encompass institutional medical care. The amici provide in-patient hospital, skilled nursing facility, and intermediate care facility services under their federally-approved Medicaid plans. Medical care provided in these institutional settings comprises a major element of the Medicaid programs of these States, as in most States in the Nation.

Providers of institutional medical care who contract with the States are reimbursed according to each State's Medicaid plan. Federal law requires that the States reimburse providers through rates that the States determine to be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . ." 42 U.S.C. § 1396a(a)(13) (1982 & Supp. III 1985). Federal law

also requires states participating in Medicaid to establish administrative review procedures for providers who wish to challenge our reimbursement decisions. 42 C.F.R. § 447.253(c) (1986).[1] Federal regulations similarly mandate the States to provide hearing rights to Medicaid applicants and recipients who believe the States have not granted them appropriate benefits. 42 C.F.R. §§ 431.220(a), 431.241(a)-(b). Numerous States, in implementing these federally mandated protections, require that the results of Medicaid review hearings be subject to judicial review in State courts under procedures akin to those provided by federal law when federal agencies set and apply reimbursement rates. *See* K. Davis, *Administrative Law* § 1:11 (Supp. 1982) (administrative procedure acts); *cf. Bowen v. Michigan Academy of Family Physicians,* 106 S. Ct. 2133 (1986); *Heckler v. Ringer,* 466 U.S. 602 (1984); *United States v. Erika, Inc.,* 456 U.S. 201 (1982).

This case affords the Court an opportunity to consider the availability of 42 U.S.C. § 1983 as a remedy for providers of institutional care who contract with the States and seek review of the States' reimburse-

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[1] These administrative appeal procedures are set forth, for example, at Alaska Stat. § 47.07.075 (1984); Cal. Welfare and Institutions Code § 14087.27 (1987); Haw. Admin. R. § 17-748 (1985); Idaho Code, §§ 56-132, -133 (1986); Kan. Stat. Ann. § 75-3306 (1984): Maine Med. Assistance Manual § 1.18 (1979); Mo. Rev. Stat. §§ 208.156, 621.055 (1983); Nev. Medicaid Services Manual § 506 (1987); N.C. Admin. Proc. Act, Articles 3 and 4, Chapter 150B (1986). N.D. Admin. Code § 75-02-06-16(7) (1986); Ohio Rev. Code § 5111.06 (1981); Vt. Stat. Ann. Tit. 33, § 195 (1978); Utah Code Ann. § 26-23-2 (1984); Va. Code § 9-6.14:1 (1985); Wash. Rev. Code § 74.46.770 (1987); Wis. Stat. § 227.42 (1985-86).

ment decisions. Medicaid providers are certainly entitled to have their state reimbursement decisions reviewed, but that entitlement does not imply that the Civil Rights Act of 1871 should be the vehicle for that process. The amici States believe that Congress's intent in developing the Medicaid program was to allow provider reimbursement review at the state administrative level and not in federal court.

The amici have a vital interest in the resolution of this case. Each of us makes reimbursement decisions annually, if not biennially, to thousands of Medicaid providers in our respective States. Each of us, as well as all remaining States that participate in Medicaid, have administrative review procedures for institutional providers that seek review of reimbursement decisions. These diverse procedures, which are designed in light of State administrative practice, but subject to federal review by the Secretary of Health and Human Services, will be disrupted, if not completely thwarted, if § 1983 is applied according to the decision in *Coos Bay Care Center v. Oregon.*

These substantial interests warrant the submission of this amici brief in support of Oregon's efforts to obtain review by this Court of the lower court's decision that Medicaid institutional providers may seek federal court review, through § 1983, of the States' reimbursement decisions.

SUMMARY OF ARGUMENT

Providers of institutional medical care who contract with the States to provide services to Medicaid recipients are not entitled under 42 U.S.C. § 1983 to seek federal court review of State Medicaid reimbursement decisions. This is true both because Con-

gress and the Secretary of Health and Human Services have directed that Medicaid reimbursement decisions be reviewed in State administrative proceedings, subject to those added review mechanisms that the States provide, and because, at least once the State medicaid plan is in place, providers, as opposed to recipients, do not enjoy any federal "rights, privileges, or immunities," with respect to reimbursement.

The degree to which the Ninth Circuit's decision vastly expands the reach of § 1983 as a vehicle for bypassing federally-mandated administrative proceedings in States across the Nation warrants plenary review by this Court.

ARGUMENT

This Court has made plain that there are ". . . two exceptions to the application of § 1983 to remedy statutory violations: where Congress has foreclosed such enforcement of the statute in the enactment itself and where the statute did not create enforceable rights, privileges or immunities within the meaning of § 1983." *Wright v. City of Roanoke Redevelopment & Housing Authority,* 107 S.Ct. 766, 770 (1987) (citing *Pennhurst State School and Hosp. v. Halderman,* 451 U.S. 1, 19 (1981); *Middlesex County Sewerage Auth. v. National Sea Clammers Ass'n,* 453 U.S. 1 (1981); *Smith v. Robinson,* 468 U.S. 992 (1984)).

The lower court's conclusion that neither of these exceptions applied to Medicaid reimbursement decisions, Pet. App. A-3, A-4, completely ignored the reasons why the federal Government has mandated *state* procedures as the vehicle for challenging such decisions, as well as numerous decisions by the lower

courts that reaffirm that "[t]he health care practitioner 'is not the intended beneficiary of the Medicaid program.' " *Silver v. Baggiano,* 804 F.2d 1211, 1216 n.3 (11th Cir. 1986) (quoting *Geriatrics, Inc. v. Harris,* 640 F.2d 262, 265 (10th Cir.), *cert. denied,* 454 U.S. 832 (1981); *Green v. Cashman,* 605 F.2d 945, 946 (6th Cir. 1979)).

I.

In sweeping away the States' procedural processes for adjudicating reimbursement decisions, the Ninth Circuit adopted a view of those procedures that is demonstrably wrong. Whereas the court held that "Title XIX *permits* states to establish administrative review procedures for disputes over Medicaid reimbursements," Pet. App. at A-3 (emphasis added), the federal regulations are inalterably mandatory: each state is required to provide ". . . an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review . . . ." 42 C.F.R. 447.253(c).

The consequences of allowing a Medicaid provider to bypass these processes are enormous. As this Court held last Term, it is common in entitlement programs to preclude *entirely* judicial review of individual reimbursement decisions, so as to " ' "avoid overloading the courts" ' with ' "trivial matters," ' a consequence which would ' "unduly ta[x]" ' the federal court system with ' "little real value" ' to be derived by participants in the program[.]" *Bowen v. Michigan Academy of Family Physicians,* 106 S. Ct. 2133, 2138 (1986) (quoting *United States v. Erika, Inc.*, 456 U.S. 201, 208 (1982) (quoting legislative history)).

A State administrative hearing is the most appropriate forum for considering the fairness of provider reimbursement decisions. Medicaid reimbursement decisions are based on extensive technical material. These decisions are best judged through administrative appeals procedures such as those that have been established by the States. As Congress and the Secretary intended, State appeal processes have been carefully tailored to local conditions in recognition of the highly technical nature of Medicaid reimbursement decisions.

The lower court's decision also poses a substantial obstacle to Congress's repeatedly stated expectation that federal review procedures be "less administratively burdensome" upon the States. *See* 48 Fed. Reg. at 56047 (1983). Requiring the States to defend reimbursement decisions in federal court greatly increases administrative cost because the States have spent their resources, as they must, in providing State administrative remedies for the Medicaid providers.

The Ninth Circuit's decision in this case is particularly disturbing because here, as in *Erika,* there is strong indication that the federal government intended to bar resort to the lower federal courts. As the Secretary stated in 1983, "absent any statutory mandate, there is no Federal authority to require judicial recourse (presumably [even] in State courts) for providers dissatisfied with State payment rates." 48 Fed. Reg. 56046, 56052 (1983) (emphasis added).

In addition, Congress and the Secretary recognized that, in most States, as in Oregon, there would be judicial review as to these statutory issues by a *state* court. Most States, like Oregon, have administrative procedure acts that ensure that agency action com-

plies with relevant administrative directives, including, for example, requirements of the State Medicaid plan. As the Secretary stated in promulgating the procedural requirements for Medicaid plans, "providers are free to pursue whatever judicial remedies are available in their *States* after they have exhausted the administrative appeal process." 48 Fed. Reg. at 56052 (emphasis added). That statement should have sufficed to preclude § 1983 claims by Medicaid providers and applicants as to particular reimbursement decisions. *Compare Wright,* 107 S. Ct. at 772 (§ 1983 review is available in part because Secretary stated explicitly that federal regulation " 'does not preclude Federal court review' ").[2]

Believing "that fair and reasonable rate adjustments are implicit in a [state] appeals' process," Congress and the Secretary explicitly endorsed granting States broad discretion in developing their review procedures, and thus saw "no need for . . . prescriptive Federal requirement[s]." 48 Fed. Reg. 56052 (1983). By allowing providers to bypass these review proce-

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[2] Of course, it was not necessary for Oregon to succeed on a claim that Congress precluded § 1983 review entirely. In addition, the court of appeals should have affirmed if Medicaid reimbursement falls within that group of claims as to which Congress has intended to abrogate the general rule that exhaustion of administrative remedies is not required under § 1983. *See Wright,* 107 S. Ct. at 773; *Patsy v. Board of Regents,* 457 U.S. 496, 507-512 (1982). The Ninth Circuit unjustifiably refused even to consider whether, in light of the well-established rules requiring exhaustion in federally-administered medical assistance programs, *see Heckler v. Ringer,* 466 U.S. 602, 612 (1984), Congress should be deemed to have intended a more burdensome process of wide-open judicial review for those federal programs administered by the States.

dures, the Ninth Circuit nullified this broad discretion established pursuant to federal direction by making our review procedures meaningless whenever a provider invokes § 1983.

II.

The Ninth Circuit erred just as egregiously in assuming that institutional care providers who contract with the States are beneficiaries of the Social Security Act and, accordingly, that § 1983 was available even if the federal Government had not "forceclosed such enforcement of the statute in the enactment itself." *Wright,* 107 S. Ct. at 770. As the Second Circuit held in *Oberlander v. Perales,* 740 F.2d 116, 119 (2d Cir. 1984), "there is no authority anywhere supporting the proposition that a state Medicaid regulation becomes a federal law merely by virtue of its inclusion in a state plan required by federal law." *See also Case v. Weinberger,* 523 F.2d 602, 607 (2d Cir. 1975) ("benefits to a nursing home from its participation in Medicaid reimbursement result from nothing more than a statutory business relationship").

The only "rights" that Medicaid providers may be entitled to under the Social Security Act are rights to reimbursement ". . . which the state finds . . . are reasonable and adequate . . ." 42 U.S.C. § 1396a(a)(13)(A).[3] Such language is not the language

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[3] The institutional provider is of course free to stay out of the Medicaid program, *see Minnesota Assn. of Health Care Facilities v. Minn. Dept. of Public Welfare,* 742 F.2d 442, 446 (8th Cir. 1984). Because Medicaid providers voluntarily contract with the States, the States will be careful to avoid errors so as to encourage the broadest participation. Nor can there be any "tak-

of rights. Indeed, the lower court decisions on which the panel below relied held that this language is enforceable by § 1983 only with respect to the *procedural* requirements that must be met before a State's Medicaid plan will be deemed valid under federal law. *See Nebraska Health Care Ass'n v. Dunning,* 778 F.2d 1291 (8th Cir. 1985), *cert. denied,* 107 S. Ct. 947 (1987); *Washington State Health Facilities Ass'n v. State of Washington Dep't of Social & Health Servs.,* 698 F.2d 964 (9th Cir. 1982); *California Hospital Ass'n v. Obledo,* 602 F.2d 1357 (9th Cir. 1979). Even if these lower court decisions are correct, which we doubt, the Ninth Circuit here went far beyond such a rationale. Rather, the court below held that the Social Security Act establishes *substantive federal* rights allowing providers to block under § 1983 any administrative action that can be pleaded as a violation of the State Medicaid plan.

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ing" of vested rights where, as here, medical care providers prospectively refuse to provide services out of fear that they will not be reimbursed, and, for that reason, patients "do not receive the full amount of appropriate care." Pet. App. 35. *See F.C.C. v. Florida Power Corp.,* 55 U.S.L.W. 4236, 4238 (U.S. Feb. 25, 1987); *O'Bannon v. Town Court Nursing Center,* 447 U.S. 773, 796 (1980) (Blackmun, J., concurring in the judgment); *Kizas v. Webster,* 707 F.2d 524, 539 (D.C. Cir. 1983), *cert. denied,* 464 U.S. 1042 (1984). This is so because there can be no "taking" of property by rate regulation unless "private property [has been] devoted to public uses[,]" and allowed rates are "confiscatory." *Florida Power,* 55 U.S.L.W. at 4238. *See also MacDonald Sommer, & Erates v. Yolo County,* 106 S. Ct. 2561, 2568 n.8 (1986) (taking claimants must make "meaningful" efforts to seek exemptions). The court of appeals recognized this truth, but then went on to sanction broad statutory challenges to reimbursement decisions. *Cf. United States v. Riverside Bayview Homes,* 106 S. Ct. 455 (1985).

Thus, although the providers in the lower court did not allege that Oregon failed to comply with the procedural requirements for the approval of Medicaid plans, the court of appeals nevertheless allowed wide-open litigation in the federal courts under § 1983 over whether States have "violate[d] the standard set out in 42 U.S.C. § 1396a(a)(13)(A)." Pet. App. 5. This broad reading of the Social Security Act unduly extends the "enforceable rights, privileges, and immunities," established by the Act, and opens the federal courts to a flood of lawsuits by institutional providers. *Cf. Block v. Community Nutrition Institute,* 467 U.S. 340, 352 (1984). Moreover, as petitioners have ably demonstrated, the Ninth Circuit's decision creates a gaping conflict with the Second Circuit's decision in *Oberlander v. Perales,* 740 F.2d 116, 119 (2d Cir. 1984), and with the jurisdictional principles of *Pennhurst State School & Hospital v. Halderman,* 465 U.S. 89 (1984). These conflicts merit plenary review by this Court.

CONCLUSION

Amici have sought to show that providers of institutional medical care who contract with the States to provide services to Medicaid recipients are not entitled under 42 U.S.C. § 1983 to federal court review of the merits of state Medicaid reimbursement decisions. Amici respectfully urge the Court to grant Oregon's petition, and to undertake plenary review of the decision below, which in unprecedented fashion disrupted a carefully tailored federal scheme that provides federal aid to the States in our efforts to expand the availability of medical care to those in our communities who are unable to afford it.

Respectfully submitted,

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